DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13149 (01/05)

STATE OF WISCONSIN
P.L. 104-191

WISCONSIN MEDICAID
HIPAA PRIVACY ACCOUNTING REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHFS, as a covered entity, to implement processes that give patients certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

Wisconsin Medicaid
Recipient Services
PO Box 6678
Madison WI 53716-0678

SECTION I — RECIPIENT INFORMATION

Name — Last, First, Middle Initial	Wisconsin Medicaid Identification Number
Address — Street, City, State, ZIP Code	Telephone Number ( )

SECTION II — ACCOUNTING OF DISCLOSURE POLICY SUMMARY

To request a disclosure accounting, please complete this form.

You have the right to an accounting of the disclosures that the Wisconsin Division of Health Care Financing (DHCF) or our business associates have made of your protected health information. The accounting period is the six years prior to your request, except for disclosure made before April 14, 2003 (the compliance date under the federal privacy rules), to which you are not entitled. This list will not include disclosures we or our business associates made to provide treatment to you or to make or obtain payment for your health care services, for our health care operations, for national security, or for use by prisons or law enforcement officials. This list will also not include information released to you by the DHCF that you requested in writing, or information released to persons who are involved in your care.

You are entitled to one free disclosure accounting every 12 months. The DHCF may charge you for each additional disclosure accounting you request during the same 12-month period. If the DHCF is going to charge you, you will be notified of the charge, in writing before the disclosure accounting is mailed to you.

SECTION III — SIGNATURES

I request an accounting of the disclosures of my protected health information as described above, made by the DHCF, within the six years prior to the date of this request. This will not include disclosures made by the DHCF prior to April 14, 2003. I understand that I am entitled to one free disclosure accounting every 12 months.

SIGNATURE — Recipient	Date Signed

If this request is by a personal representative on behalf of the recipient, provide a copy of the documentation to support the representation and complete the following:

Name — Personal Representative	Relationship to Recipient
SIGNATURE — Personal Representative	Date Signed